

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	St. Brigid's Hospital
Centre ID:	OSV-0000672
Centre address:	Carrick on Suir, Tipperary.
Telephone number:	051 640 025
Email address:	Carmel.lonergan1@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bridget Farrell
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	13
Number of vacancies on the date of inspection:	3

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 August 2017 08:30	01 August 2017 17:30
02 August 2017 08:00	02 August 2017 15:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of a two day announced inspection of St Brigid's Hospital and was a follow-up to an inspection carried out in November 2016. During the inspection, the inspector met with a number of residents, staff members, the person in charge and the provider representative. This inspection report sets out the findings of this monitoring inspection.

St Brigid's Hospital provides convalesce, respite and palliative care and is registered to accommodate 16 residents. On the first day of inspection there were 13 residents in the center. The center is run by the Health Service Executive (HSE) and is located on the outskirts to Carrick on Suir town. It was built and founded as a fever hospital in 1817 and while there have been many changes, renovations and improvements

since then, the design and layout of the premises was largely reflective of a small hospital from this period in which it was built. The older and main part of the hospital comprised of three floors with residents' bedrooms on the ground and first floors. The third floor accommodated staff changing room, offices and storage room for equipment. Resident accommodation consisted of three en-suite palliative care single bedroom suites on the ground floor. There is one twin bedroom, one single bedrooms and two five-bedded rooms that are located on the first floor and are utilized for convalescence and respite care.

The inspector found that residents' healthcare and nursing needs were met to a good standard. Residents had easy access to medical, allied health and psychiatry of later life services. The center was supported by a number of the allied health staff including physiotherapy based on site and the visiting Clinical Nurse Specialist (palliative home care team). Staff interacted with residents in a kind and respectful manner and the inspector found that residents appeared well cared for. Residents were spoken with throughout the inspection. The feedback received from them was generally very positive and indicated that they were satisfied with the staff and care provided. However, the inspector noted that there had been complaints received in relation to one of the five bedded multi-occupancy bedrooms and this issue is outlined in the relevant sections of the report.

Since the previous inspection in November 2016, there have been a number of changes to the governance and management of the center which included changes to the person in charge. The person in charge had been working in the center as a Clinical Nurse Manager 2 (CNM) since September 2015 and was appointed as acting Director of Nursing and person in charge in January 2017. An interview was conducted with the person in charge during this inspection. The person in charge displayed good knowledge of the regulatory requirements and was found to be committed to providing evidence-based care for residents.

During this follow-up inspection the inspector reviewed the actions arising from the previous inspection conducted in November 2016. The inspector noted that both the person in charge and the provider representative were proactive in their response to a number of actions required from the last inspection. However, a number of actions remained non-compliant and some further actions were required on this inspection including actions in relation to the premises. There were 18 actions that arose following the center's previous inspection in November 2016. Of those, 13 had been satisfactorily addressed and five had not been satisfactorily progressed. These are discussed throughout the report and related mainly to ongoing premises issues and its' impact on residents' privacy and potentially their dignity. The impact of the inadequate premises was somewhat mitigated by the short length of stay for residents which was under 30 days and averaged for most residents at 10 days. This was confirmed by the provider representative and the admission/discharge criteria as stated in the statement of purpose. The statement of purpose stated that "on average the length of stay for convalescent patients is two weeks, but this may be extended if the medical officer deems the person to be medically unfit for discharge. The statement of purpose also stated that in relation to "the exit pathway: Patients are discharged once their baseline health is achieved and family/home care package is in place".

There were improvements required in relation to the provision of activities, health and safety, complaints and documentation. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The center was operated by the Health Service Executive (HSE) who was the registered provider. HIQA had received notification in January 2017 that the previous DON and person in charge had left the centre and had been replaced by the Clinical Nurse Manager 2 (CNM2) who was now acting DON. The inspector interviewed the person in charge and noted that she was in a full time role and was supported on a daily basis by the CNM2. The inspector also spoke to the provider representative and noted the management team displayed adequate knowledge of the regulatory requirements. They were proactive in response to a many of the actions required from previous inspections. The inspector viewed a number of improvements throughout the center. For example, there had been significant repainting of many areas including residents' bedrooms, the corridors and the palliative care suites. In addition, furniture had been repaired and the center had acquired new equipment such as a new shower chair, two low-low beds and bed and chair sensor alarms which the person in charge stated would assist in promoting a restraint free environment. There had been some improvement in staff training. However, as previously identified some actions required further attention/action and a number of actions remained non-compliant. In particular, the design and layout of the two five bedded rooms continued to be inadequate to meet the individual or collective needs of residents in these bedrooms. The design and layout of these bedrooms did not adequately protect residents' privacy and potentially residents' dignity. The provider acknowledged that these bedrooms were not suitable and stated that there had been a recent meeting with the HSE engineers in relation to potential solutions to this issue. However, the provider representative stated that they did not have any further information or definite plans at this time in relation to this on-going non-compliance.

The inspector spoke with staff, the provider representative and the person in charge. All outlined a clearly defined management structure that was in place. This structure

identified who was in charge, who was accountable to whom and the reporting relationships within the organisation. Staff who spoke with the inspector were able to demonstrate good knowledge of this system. There was a copy available of the annual review into the quality and safety of care delivered in the center for 2016, as required by regulation. There was a system in place to improve the quality and safety of the service. This included the person in charge supported by other staff, undertaking regular audits. These audits were available to the inspector and included, amongst others: hygiene and infection control, nutrition, medication management, end of life care and nurse documentation. The person in charge outlined how these audits help inform the quality and governance of the centre. The person in charge explained how the findings and actions from these audits were being used to focus areas for improvement in the center. The provider representative was based in Clonmel town and spoke with the person in charge regularly by phone and was in daily email contact. They also met as required for example, the recent meeting held last week in relation to the aforementioned premises issues. In addition, they met at senior management meetings including quarterly quality and improvement meetings, six monthly health and safety meetings and six monthly fire safety meetings.

There was evidence of meetings with staff and since the last inspection there was evidence of regular meetings were held with residents. The inspector noted that the person in charge was well known to residents to whom the inspector spoke with. There was a regular change in the resident population with the average length of stay of seven to ten days. The person in charge stated that she therefore made getting to know all residents a priority and described how she spoke to all residents in the center each day and attended the morning handover meeting each day. The person in charge stated that the chair of the residents' committee meetings was rotated to encourage residents' participation. The most recent residents' meeting was recorded as being held on 15 June 2017. From a review of the minutes of these meetings it was clear that issues identified were addressed in a timely manner and that the person in charge was proactive in addressing any concerns or issues raised.

Where areas for improvement were identified in the course of this inspection; the person in charge and the provider representative demonstrated a conscientious approach to addressing these issues in a robust manner. Both displayed a commitment to compliance with the regulations. For example, on the previous inspection, complaints and the management of same were not subject to review and non-compliances were not identified following receipt of complaints. However, on this inspection improvements were noted in relation to the management of complaints including the recording of complaints, the learning and corrective actions taken.

Inadequate resources had been identified on the previous inspection and staff spoken to identified that staffing had been an issue. This was an issue particularly when replacement staff were required. For example, due to an unexpected vacancy such as sick leave. However, the person in charge and staff to whom the inspector spoke, stated that overall this issue had been now resolved. Staffing was generally stable with improvements in available staffing resources including the twilight hours and access to agency staff, if required. This issue was further outlined under outcome 18 of this report.

Staff were observed taking time especially in the afternoon to sit and chat with residents and play cards or board games if the resident was interested in same. However, as identified on the previous inspection there was no structured or planned activities provided. This was further discussed under outcome 16 of this report.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A sample of residents' contracts of care were viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and outlined all of the services and responsibilities of the provider representative to the resident and the fees to be paid. However, contracts of care reviewed did not contain details of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

HIQA had received notification in January 2017 that the previous Director of Nursing (DON) and person in charge had left the center and had been replaced by the CNM2 who was now acting DON. The inspector interviewed the person in charge and noted that she was in a full time role and was supported on a daily basis by one CNM2. The person in charge had also worked as a CNM2 in the center since 2015 and displayed a good knowledge of the standards and regulatory requirements.

The inspector interacted with the person in charge throughout the inspection process over the two days and found the person in charge to be committed to providing quality person-centred care to the residents. There was evidence that she was actively engaged in the governance, operational management and administration of the centre on a day-to-day basis. The person in charge had sole senior managerial responsibility for this center and she attended the morning handover each day and spoke to every resident. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years' experience in nursing of the older person within the previous six years, as required by the regulations. She had a commitment to her own continued professional development and she had regularly attended relevant education and training sessions which was confirmed by training records. There was evidence that she had attended a comprehensive range of post graduate training including palliative care and was a qualified manual handling instructor.

Staff and residents all identified her as the person who had responsibility and accountability for the service and said she was approachable. It was clear that she always made herself available to them whenever they needed to discuss anything with her.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector reviewed the available documentation for matters detailed in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centers for Older People) Regulations 2013. Up-to-date, site specific policies and procedures were in place. Copies of both the standards and regulations were maintained on site and copies of the statement of purpose, the residents guide and most recent inspection report were kept near the entrance. All of the records to be maintained by the center, in accordance with Schedule 3, such as a complaints log, records of notifications and a directory of visitors were available. However, records required under Schedules 3 of the Regulations were not adequate for example the end of life care plan was not comprehensively completed for one resident who was recently in receipt of palliative care. This finding was detailed and actioned under outcome 11 of this report. There was a suitable plan for responding to emergencies including fire and evacuation procedures were in place. However, documentation relating to personal emergency egress plans (PEEP's) were not adequate and this failing was detailed in outcome 8 of this report.

Records and documentation available were securely controlled, maintained in good order and retrievable for monitoring purposes. A current insurance policy was available verifying that the center was adequately insured against accidents or injury to residents, staff and visitors.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. The person in charge stated that there were no volunteers currently working in the center. The provider representative confirmed that with the exception of one staff; all staff had Garda vetting documentation in place. In relation to this one member of staff the provider stated that all paper work had been completed and forwarded for vetting.

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The person in charge confirmed that there was no active reported, suspected or alleged

incident of abuse in the center. The inspector was satisfied that there were policies and procedures in place for the protection of residents. The person in charge was actively engaged in the operation of the center on a daily basis. There was evidence of good recruitment practices including verification of references and a good level of visitor activity. The provider representative confirmed that with the exception of one staff member; all staff were suitably Garda vetted. This issue was actioned under outcome 5 of this report. The national HSE safeguarding policy was in place for the prevention, detection and management of any protection issues. The inspector spoke to staff and met the nominated safe guarding officer. All staff spoken to confirmed their attendance at elder abuse/safeguarding training and were clear on their responsibilities including the role of the designated safeguarding officer. Training records also evidenced that since the previous inspection, all staff had been trained in safeguarding vulnerable adults from abuse.

The inspector saw that there was positive and respectful interactions between staff and residents. Residents were comfortable in asserting themselves and bringing any issues of concern to any staff, CNM's or to the person in charge. Many residents spoken to were able to articulated clearly that they had full confidence in the staff and expressed their overall satisfaction in the care being provided. In relation to residents' financial transactions, the person in charge confirmed that the center did not manage any residents' day to day expenses. However, there was a small number of residents financial transactions managed by the center. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of residents' records of monies/financial transactions. The inspector noted that all lodgements and withdrawals were adequately documented or signed for by residents, their representatives and/or two staff. There was a HSE financial accounting system in place which provided for suitable written acknowledgement receipts or return of valuables to be provided. These arrangements were subject to six monthly audits by an external auditor as well as on-going local review arrangements to ensure good financial governance.

Since the previous inspection there had been continuous improvements in the management and reduction in the incidence of restraint in the center. The person in charge and staff to whom the inspector spoke; stated that they were fully committed to providing a restraint free environment. The person in charge informed the inspector that there was no restraint or restrictive practices in the center. The person in charge outlined how the acquisition of additional low-low beds and bed and chair alarms had help reduce the incidence of restraint. Staff stated that they actively sought to provide alternatives to bedrails whenever possible and this was evidenced from a review of residents care plans.

At the time of inspection there were no residents with responsive behaviours (a term used to describe how persons with dementia represent how their actions, words and gestures are a response to something important to them). Staff to whom the inspector spoke were knowledgeable in providing suitable de-escalating techniques. The person in charge and nursing staff confirmed that any residents who presented with responsive behaviours were reviewed by their General Practitioner (GP) and referred to other professionals for review and follow up as required. Staff spoken to outlined suitable practices to prevent responsive behaviours including using person-centered de-

escalation methods. However, training records evidenced that all staff had not received up-to-date training in this area. The training matrix recorded that training in dementia care had been provided. However, these records also evidenced that not all staff have received this training in dementia care.

As previously identified the design and layout of the two five-bedded rooms continued to be inadequate to meet the individual or collective needs of residents in these bedrooms. As detailed under outcome 12 of this report; the design and layout of these two five-bedded bedrooms they continued to be inadequate to protect residents' privacy and potentially compromised residents' dignity. The space between beds in each five bedded ward was very limited which posed a restriction on movement for staff delivering care at the bedside. The lack of space also reduced the amount of furniture or personal memorabilia that could be accommodated. This inadequacy was somewhat mitigated by the following; only residents that had low dependency needs and who were mobile occupied the middle of these three beds. Residents occupied these beds for short length of stay only, which was under 30 days and the averaged stay recorded for most residents was on average 10 days. In addition, the admission/discharge criteria as stated in the statement of purpose stated that "on average the length of stay for convalescent patients was two weeks, but this may be extended if the medical officer deems the person to be medically unfit for discharge. The statement of purpose also stated that in relation to "the exit pathway: Patients are discharged once their baseline health is achieved and family/home care package is in place". This issue was therefore actioned under outcome 12 of this report.

Judgment:

Substantially Compliant

***Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.***

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Since the previous inspection there had been improvements in the overall décor of the premises including painting of a number of areas to ensure effective cleaning could take place. Overall the premises, including the communal areas and bedrooms were found to be generally clean and there was adequate standard of general hygiene at the center. The circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. There was personal protective equipment such as latex gloves and plastic aprons available in designed cupboards. Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in

place. For example, regular training of staff and strategic placed hand sanitizer dispensers throughout the premises. The inspector spoke to a number of staff who demonstrated adequate knowledge of hand hygiene and infection prevention and control practices. However, as identified on the previous inspection, the water taps of the hand washing sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices.

A closed circuit television (CCTV) system was in place that covered external areas. The arrangements for evacuating, in the event of fire, all persons in the center required review. All visiting contracted workers such as electricians or plumbers for example, were required to sign in and out into a visitor's log. However, for all other's including residents, visitors or staff in the center; there was no register/record maintained. Therefor there was no contemporaneous record of residents, other visitors or staff who were in the premises at any given time.

Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. The inspector noted that the emergency lighting was most recently serviced in June 2017 and the fire alarm was also serviced in June 2017. Certification of testing and servicing of fire extinguishers and fire retardant materials were also documented most recently in September 2016. The building had fire and smoke containment and detection measures in place. Staff had received training in fire safety within the past 12 months. Staff spoken to were familiar with what actions to take in the event of a fire alarm activation and with the principles of horizontal evacuation. Practiced fire drills were held, that included simulation of an evacuation to determine the competency of staff to use evacuation equipment such as evacuation sheets. The inspector viewed records of the practiced fire evacuation drills which identified where improvements to the procedure could be made. All residents had personal emergency egress plans (PEEPs) which identified the level of mobility and evacuation mode of each resident. However, these plans required improvement including the provision of a current photograph of the resident, the level of supervision of the resident after evacuation and whenever possible, consultation with the resident in relation to their own PEEP.

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the centre. The internal and external premises and grounds of the center appeared safe and secure, with appropriate locks installed on all interior and most exterior doors. However, there was one exit door that was unsecured during day time and required a risk assessing in relation to its suitability. In addition, the inspector noted that there was anaglypta paintable wall covering on the ceiling of the dining room. However, this wall covering appeared to be lifting in places and required a risk assessment as to its suitability.

There were appropriate arrangements for investigating and learning from serious incidents/adverse event which identified for example residents who were at risk of falls and put in place appropriate measures to minimise and manage such risks. Each serious reportable event (SRE) was suitably recorded. Each was escalated to senior management as per the HSE safety incident management policy January 2017 and reporting protocols. Following any such incident, accident or event, the provider representative and the person in charge along with other staff met at a senior incident

management team meeting. Following each SRE these meetings were held to ascertain if there was any learning opportunities or corrective actions that needed to be taken. For example, for residents who had fallen, there were falls risk re-assessments completed after each fall and care plans were updated accordingly. Suitable governance and supervision systems were in place for the on-going monitoring of residents at risk of falls. Such arrangements were reviewed on an on-going basis. There was a risk register available in the center and the inspector found that the hazard identification process was adequate. There was an up-to-date risk management policy that addressed the identification and assessment of risks and the controls that were in place including the requirements of the regulations.

The centre had other policies relating to health and safety including a safety statement. There was a plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property. There was a record of incidents and accidents in the centre which recorded slips, trips and falls and records seen were adequate to ensure arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Care plans contained a current manual handling assessment and plan that referenced the specific equipment required for resident and staff safety. The person in charge was a trained manual handling instructor and manual handling practices observed were seen to be in line with current best practice. The training matrix recorded that all staff were trained in manual handling. Documentation seen indicated that the hoist required for moving techniques in resident care were serviced regularly and the person in charge confirmed that all residents had the use of their own individual sling if required.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were up-to-date. Staff were observed adhering to appropriate medication management practices. The medication trolleys were suitably secured and the medication keys were held by the nurses on duty. Medications were administered and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in

accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, GP and details of any allergy. There was a system of on-going audit and analysis in place for reviewing and monitoring safe medication management practices. Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records.

There were appropriate procedures for the handling and disposal of unused and out of date medicines and the documenting of same. The fridge containing medications was securely located in the clinic room near the nurses' office. There was evidence that the temperature of the fridge was monitored daily and that the fridges contained medication only.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The center provided short stay convalesce, respite and palliative care and was registered to accommodate 16 residents. The inspector was noted that the length of stay for most residents in the center was under 30 days. With the average stay for most residents was 10 days. This was confirmed by the provider representative and the admission/discharge criteria as stated in the statement of purpose. The statement of purpose stated that "on average the length of stay for convalescent patients is two weeks, but this may be extended if the medical officer deems the person to be medically unfit for discharge. The statement of purpose also stated that in relation to "the exit pathway: Patients are discharged once their baseline health is achieved and family/home care package is in place".

On the first day of inspection there were 13 residents living in the center. Staff had assessed the level of residents' dependence in their activities of daily living assessments as follows; four medium, three high dependency and six residents at maximum dependency needs. The inspector was satisfied that residents' healthcare requirements were met to a good standard. The person in charge informed the inspector that the average stay for residents was seven to 10 days. That many residents had been referred from hospital or the community. Residents had access to a physiotherapist who was based on site. The inspector observed that the Clinical Nurse Specialist (CNS) from the palliative home care team provided on-going support to residents in the center. In the context of the frequent admissions and discharges in the center; the inspector noted that suitable arrangements were in place for resident information to be provided to nursing staff on admission. In addition, suitable arrangements were also in place for the onward referral to allied health professionals as part of the discharge plan for each resident. For example, such referrals included communications with the public health nursing service to ensure adequate support was in place prior to the residents' discharge. These admission and discharge arrangements were evidenced from the selection of residents' care plans reviewed and from speaking to the person in charge and nursing staff.

The inspector spoke to a number of residents who confirmed that they were well cared for. Many residents were very complementary about the kindness and standard of care provided to them by all staff. Some residents had been admitted for respite care and were well known to all staff. While other residents were recently transferred from acute hospital and required more nursing care, monitoring and support. There was evidence that there were suitable arrangements in place to meet assessed healthcare needs of residents. On admission, each resident was seen by a nurse' and each residents' healthcare requirements were adequately and regularly assessed by competent nursing staff, as required.

On admission residents were facilitated to retain access to their GP of preference and there was four different GP practices supporting the center on the days of inspection. There was documentary evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, chiropody and on site physiotherapy. Each resident had a nursing plan of care in place and the inspector reviewed a random sample of care plans. On the previous inspection there had been a number of improvements required in relation to the care planning documentation. However, the inspector noted that there had been improvements in the care plans. Overall, the inspector was satisfied that the system was clearly understood by staff and the general standard of care planning was adequate. There was evidence that each care plan was informed by assessment and reassessment as required. Care plans were completed in consultation with the resident and/or their representative and were supported by a suite of validated assessment tools. In general, care plans were person centred, clearly set out the arrangements to meet most identified needs as specific to each resident. They were seen to also incorporate interventions prescribed by other healthcare professionals. However, the inspector noted from this sample of care plans reviewed that not all residents' care plans were adequately comprehensive. For example, a number of sections of some care plans were left blank and there were no end of life care plan in one residents' care record. In addition, the social care needs of each resident had been

assessed. However, this information including the resident's preferences, were not used to plan to meet their social needs for the duration of their stay. This information did not form part of a social care plan to provide opportunities for residents to participate in activities in accordance with their interests and capacities. This issue was also discussed under outcome 16 of this report.

A daily nursing narrative record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations.

There was a low reported incidence of wounds and none at the time of inspection. The inspector saw that the risk of wound development was regularly assessed as required. Preventative strategies including pressure relieving equipment were implemented. A validated assessment tool was used to establish for each resident at risk of falling and there was evidence of the routine implementation of falls and injury prevention strategies including close monitoring of residents. The resident's right to refuse treatment was respected and recorded and brought to the attention of the relevant GP.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The premises was built as a fever hospital in 1817 and there have been many changes, renovations and improvements since then. However, the design and layout of the premises was largely reflective of a small hospital from the period in which it was built. The older and main part of the hospital comprised of three floors with resident bedrooms on the ground and first floors. The third floor accommodated staff changing and rest rooms and storage for equipment. Resident accommodation consisted of three en-suite palliative care single bedrooms suites on the ground floor. Each suite also had access to the garden to the rear of the premises. There was one twin bedroom, one single bedroom and two five-bedded rooms on the first floor which were mainly utilised for convalescence and respite care. There was a separate room available for residents to

meet relatives or visitors in private if they wished. All bedrooms contained wash-hand basins and there were adequate number of showers and toilets to meet residents needs on the days of inspection. There had been improvements in providing a more homely feel to the center, with more pictures on walls and clocks in each room. The grounds were well laid out with ample parking available to the front which was also contained a clearly identified fire assembly point. Residents had access to the outside space including the grounds around the premises and the very pleasant rear walled-in garden area. This garden contained some lawn, potted flowers, was wheelchair accessible and with suitable seating also provided.

The premises was generally bright, warm and well ventilated. Since the previous inspection there had been considerable improvements in the décor. For example, many areas had been repainted including all residents' bedrooms, the corridors and the palliative care suites. Many of the residents spoken to expressed satisfaction with the brighter corridors and bedrooms following the repainting. In addition, furniture had been repaired and the center had acquired new equipment such as a new shower chair, two low-low beds and bed and chair sensor alarms. However, non-compliances identified in a number of previous inspections, relating to the two multi occupancy five-bedded rooms had not been satisfactorily progressed. This on-going non-compliance was therefore restated in this outcome. The design and layout of the two five-bedded rooms continued to be inadequate to meet the individual or collective needs of residents in these bedrooms. Due to the design and layout of these two five-bedded bedrooms they continued to be inadequate to protect residents' privacy and potentially compromised residents' dignity. In these two five bedded bedrooms, three beds were arranged against one wall and two beds against the opposite wall. The space between the three beds in both five bedded ward was very limited. For example, the inspector noted that there was only 76cms space between these three beds. This limited space also posed a restriction on movement for staff delivering care at the bedside. The lack of space also reduced the amount of furniture or personal memorabilia that could be accommodated. The person in charge stated that only residents that had low dependency needs, who were mobile occupied the middle of these three beds. The inspector noted that this was the case on the days of inspection. In addition, there continued to be inadequate storage in the center for residents' personal clothing or belongings and this issue was addressed and actioned under 16 of this report. The provider representative acknowledged that these bedrooms were not suitable and stated that there had been a recent meeting with the HSE engineers in relation to potential solutions to this issue. However, the provider representative also stated that they did not have any further information or definite plans at this time in relation to this on-going non-compliance. The inspector noted that the impact from the limited space for furniture or personal memorabilia that could be accommodated in the multi-occupancy bedrooms was somewhat mitigated by the short average length of stay for residents in the center. There was a single bedroom available in the unlikely event of a resident staying for a longer period of time. The inspector was informed that the length of stay for residents in the center was under 30 days. With the average stay for most residents recorded as 10 days. This was confirmed by the provider representative and the admission/discharge criteria as stated in the statement of purpose. The statement of purpose also stated that in relation to "the exit pathway: Patients are discharged once their baseline health is achieved and family/home care package is in place".

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The complaints procedure was displayed at the main entrance to the centre and it described how to make a complaint. There were copies of the HSE document "Your Service Your Say" available. The complaint's policy listed details of the nominated complaints officer within the center and included an appeals procedure. Residents spoken with said they would have no hesitation speaking to any of the staff if they had a concern. The inspector noted that many residents had low dependency needs and appeared able to self-advocate. Both of the previous two actions had been completed since the last inspection. The inspector read the small number of complaints recorded for 2017. The details of each complaint were recorded and the inspector saw that there was a response to each complaint. In addition, there was evidence of learning and some changes having been made following receipt of these complaints. For example, improved documentation regarding individual residents' preferences and arranging better access to hairdressers. However, the inspector noted from complaint records viewed, that a resident and/or their representatives had complained about the unsuitability of the two five bedded rooms. Complainants expressed concerns regarding the design and layout of the two five bedded rooms in relation to residents not been able to undertake activities in private. That both five-bedded rooms were not suitable to meet the individual or collective needs of some residents. These complaints had been recorded in January 2017. The person in charge had highlighted/escalated this issue as per HSE policy to the provider representative. While the provider representative was aware of the unsuitability of the two five bedded rooms and had recently held a meeting with the HSE engineers and the person in charge. However, the provider representative had not put in place measures required for improvement in response to these complaints.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving

visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There had been improvements in the arrangements for consulting residents on an on-going basis in order to elicit feedback as to how the center was run. For example, there was now regular residents committee meetings with the most recent meeting recorded in 15 of June 2017. From a review of the minutes of these meetings, it was evident that a wide number of issues were recorded as being discussed. Such issues included residents care, meals, residents' comfort and activities. In addition, given the size of the center with a maximum of 16 residents any given time, the person in charge spoke to each resident every day to obtain their feedback. This was confirmed by all residents to whom the inspector spoke.

Residents had access to a variety of national and local newspapers and magazines to reflect their interests and these were located in accessible areas and available to residents each day, free of charge. Residents were seen enjoying the radio and television or reading the newspapers during the inspection. As part of the activities of daily living assessment completed for every resident; a social assessment had been completed. Board games and cards were available in the day room. Staff informed the inspector that that they often encouraged residents to partake in games but generally residents were disinterested or in some cases unable to partake due to their care needs. On the days of inspection, residents who spoke with the inspector said they were happy with all aspects of the center and particularly how well they were looked after by the staff. Although there was no formal activities programme, the inspector observed that residents appeared to be content and many of them availed of opportunities to rest and recuperate following a hospital stay. The inspector formed the judgment that in the main, residents who were there for a short time were afforded opportunities for social engagement and occupation to suit their capabilities and interests'.

There was Closed Circuit Television (CCTV) cameras in place in a number of locations in the centre and there was an up-to-date policy in place. There was a notice at the entrance to the centre in relation to the use of CCTV cameras.

The inspector found that resident's privacy and dignity was generally respected. The inspector observed staff members generally knocking on bedroom, toilet and bathroom doors and waiting for permission before entering. Staff interacted with residents in a courteous and friendly manner. Residents spoken to were very complimentary about the staff in the center. Residents spoken with described the staff as very kind and said they

felt safe in the center and attributed this to staff. Residents clearly stated that they were able to exercise choice regarding how they spent their day. The inspector observed throughout the inspection that residents were consulted and encouraged to make choices about their daily routine. There was an independent advocacy service available in the center, if required.

The issue of the unsuitable design and layout of the two five-bedded rooms to meet the individual or collective needs of residents in these bedrooms had been identified under outcome 12 of this report. However, the design and layout of these two five-bedded bedrooms also impacted on the privacy and potentially dignity of residents. The inspector observed that in both of the five-bedded wards, residents had various levels of care needs, levels of mobility. Some residents required oxygen and a number required support with personal care requirements including for example the use of a commode. It was evident that having five residents with such diverse health and social care needs sharing the same bedrooms inevitably impacted on residents' privacy and potentially on their dignity. Even with the bed screens provided; it was difficult to see how some residents with reduced capacity, mobility or high care needs could undertake personal activities in private. Complaints had been received from residents and their representatives in relation to the privacy aspect of these bedrooms. As outlined in outcome 12 of this report the beds were arranged with three beds against one wall and two beds against the opposite wall. The person in charge had tried to reduce the impact on residents by ensuring that only residents with low dependency needs and were mobile occupied the middle of these three beds. In addition, the provider representative acknowledged that these bedrooms were not suitable and stated that there had been a recent meeting with the HSE engineers in relation to potential solutions to this issue. However, the provider representative stated that they did not have any further information or definite plans at this time in relation to this non-compliance.

Judgment:

Non Compliant - Moderate

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was a center-specific policy on the management of residents' personal property and possessions. From the sample of residents' records reviewed by the inspector; there

were suitable records in place of individual resident's clothing and personal items. Residents laundry was well maintained and most laundry provided off-site with bed sheets and towels laundered by a off-site laundry provider. There were appropriate arrangements in place for the regular laundering of linen and clothing and procedures were in place for the safe return of residents' personal clothing items.

Each resident had a bed side locker in their bedroom for the safekeeping of any personal items or small quantities of monies. Residents were facilitated to have some of their own items, such as assisted chairs. However, as identified under outcome 12 of this report the lack of space particularly in the two five bedded rooms reduced the amount of furniture or personal memorabilia that could be accommodated. As identified on previous inspections, there continued to be inadequate storage in the center for residents' personal clothing or belongings. Each resident had a bed side locker however, there were no wardrobes available for residents' use. The lack of storage space was also evidenced on the first day of inspection with two bags of residents' laundry was stored on the floor beside a residents' bed. In addition, a number of residents had items of clothing stored on windowsills in their bedrooms. The impact of this reduced space was somewhat mitigated by the short time frame that residents stayed in the center. In addition, the person in charge stated that only residents with low dependency needs, who were mobile; occupied the middle of these three beds within the two five bedded bedrooms. The inspector noted that this was the case on the days of inspection.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector was satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. This finding was based on the review of the staff roster, from speaking to residents and staff, the person in charge and a review of minutes of staff meetings. Staffing included at least two staff nurses on duty at all times day and night.

Residents to whom the inspector spoke described staff as being very attentive and kind in their dealings with residents and indicated that staff were caring, responsive to their needs and at all times treated them with respect and dignity. A number of staff spoken to had worked in the centre for many years. They demonstrated a good understanding of their role and responsibilities in relation to ensuring appropriate delivery of person-centred care to residents. The inspector observed very positive interactions between staff and residents over the course of the inspection. The inspector found staff to have good knowledge of residents' needs as well as their likes and dislikes.

Staff confirmed to the inspector that they had been facilitated in accessing continuing professional education by the person in charge. The person in charge outlined how she promoted and supported staff training and development. For example, the person in charge was a trained manual handling instructor and all staff had up to date training in manual handling. The person in charge also gave the example of the "shared folder" and the group email address for staff to ensure that all received updates on any policy, training or opportunities that became available. The person in charge also outlined how this arrangement was also an effective means of sharing any new developments, policies or learning from courses that individual staff might have obtained. While formal or structured appraisals had not yet commenced; the person in charge stated that she had plans for a system of appraisals that she planned to roll out/develop this year. However, from speaking to the person in charge, staff and a review of documentation; staff were supervised appropriate to their role and responsibilities. There was an education and training programme available to staff and the training matrix indicated that mandatory training was provided to most staff. A number of staff had attended training in areas such as cardio pulmonary resuscitation (CPR), fire training and medication management. However, not all staff had completed mandatory training in and responding to and manage behaviours that were challenging or dementia training. These failings were discussed and actioned under outcome 8 of this report. In addition, most, but not all staff had attended training in end of life care.

All nursing staff were on the live register with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland and many of the multi-task attendants had completed the Further Education and Training Awards Council (FETAC) level five qualifications.

The inspector reviewed a sample of staff files which included most of the information required under Schedule 2 of the regulations. The person in charge stated that there were no volunteers currently working in the center. The provider representative confirmed that with the exception of one staff; all staff had Garda vetting documentation in place. In relation to this one member of staff the provider stated that all paper work had been completed and forwarded for vetting. This issue was actioned under outcome 5 of this report.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Brigid's Hospital
Centre ID:	OSV-0000672
Date of inspection:	01/08/2017 and 02/08/2017
Date of response:	12/10/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned including details of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:

Residents are provided with details of the type of accommodation available in St. Brigid's Hospital, on pre-admission i.e. 2 x 5 bedded shared rooms upstairs, 1 x single room upstairs (For Infection Control purposes), 1 x 2 bedded upstairs (Can be used for either male or female Residents), 3 palliative suites downstairs and Day/Dining room facilities downstairs. This information is also provided in the Contract of Care.

Proposed Timescale: 12/10/2017

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector including Garda vetting for all staff.

2. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

Garda Vetting completed on all staff members

Proposed Timescale: 12/10/2017

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging including training in dementia care.

3. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:

MAPPA training took place in September 2017, which all staff attended. 4 Staff will receive training in the understanding of Dementia to enhance their skills in the care of the person with Dementia in October 2017.

Proposed Timescale: 31/10/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated center including risk assessing the rear exit door that was unsecured and anaglypta wall covering on the ceiling of the dining room.

4. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

The exit door from the Day Room (which exits onto the garden) will be incorporated into the present monitoring system to minimise the risk associated with Residents who wander.

Proposed Timescale: 31/10/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff including the provision of suitable taps for the hand washing sinks in the center's sluice facilities.

5. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the

standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

The present taps will be changed to mixer taps to comply with Infection Control guidelines.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents including the development of suitable PEEP's that include the provision of a current residents' photograph, the level of supervision of the resident after evacuation and to whenever possible consult the resident in relation to their PEEP.

6. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:

All PEEPs have a photograph of the Resident attached to it.

All Residents who require supervision as part of an evacuation process has this clearly stated on their PEEP

The level of assistance a Resident requires is also noted in the comment area of the assessment.

Proposed Timescale: 12/10/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

7. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:

The following question has been added when completing PEEP assessments:
In the event of an evacuation does the Resident require supervision: Yes/No

All PEEPs have a photograph of the Resident attached to it.

If assistance is required this is also noted.

Proposed Timescale: 12/10/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including the comprehensive completion of all care plans including the no end of life care plan record.

8. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

Staff members will receive support with documentation pertaining to end of life care in order to enhance their skills in this area

A Documentation workshop has been arranged for staff members on the 1st and 6th November. This workshop will include end of life care planning and documentation, In the short term, while awaiting training, improvement requirements will be highlighted at staff reporting and staff meetings

Proposed Timescale: 30/11/2017

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including ensuring that care plans are comprehensively completed, that all residents have an end of life care plan and a social care plan to provide opportunities for residents to participate in activities in accordance with their interests and capacities.

9. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

End of life documentation /records workshop to take place November 1st and 6th
Staff training in PALS will be provided to staff members to allow them facilitate residents in participating in activities suitable to their interests/abilities

Proposed Timescale: 30/11/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

10. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

Discussions are on-going with Technical Services in relation to the development of plans for an extension to St. Brigid's Hospital which would comply with HIQA Environmental Standards i.e. 16 single and 2 double en-suite rooms. Other options such as relocating the service to an alternative site in South Tipperary where Capital developments works will occur are also being considered. There is no capital funding secured to meet this requirement, but a business case to support this capital development will be submitted once plans are finalised.

Proposed Timescale: Ongoing April 2019

Proposed Timescale: 30/04/2019

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To put in place any measures required for improvement in response to complaints regarding the design and layout of the two five bedded rooms in relation to residents

not been able to undertake activities in private and both rooms were not suitable to meet the individual or collective needs of some residents.

11. Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:

Discussions are on-going with Technical Services in relation to the development of plans for an extension to St. Brigid's Hospital which would comply with HIQA Environmental Standards i.e. 16 single and 2 double en-suite rooms. Other options such as relocating the service to an alternative site in South Tipperary where Capital developments works will occur are also being considered. There is no capital funding secured to meet this requirement, but a business case to support this capital development will be submitted once plans are finalised.

Proposed Timescale: Ongoing April 2019

Proposed Timescale: 30/04/2019

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To provide opportunities for residents to participate in activities in accordance with their interests and capacities.

12. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:

Discussions are on-going with Technical Services in relation to the development of plans for an extension to St. Brigid's Hospital which would comply with HIQA Environmental Standards i.e. 16 single and 2 double en-suite rooms. Other options such as relocating the service to an alternative site in South Tipperary where Capital developments works will occur are also being considered. There is no capital funding secured to meet this requirement, but a business case to support this capital development will be submitted once plans are finalised.

Proposed Timescale: Ongoing April 2019

Proposed Timescale: 30/04/2019

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure that each resident may undertake personal activities in private including in the two five bedded bedrooms.

13. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:

Discussions are on-going with Technical Services in relation to the development of plans for an extension to St. Brigid's Hospital which would comply with HIQA Environmental Standards i.e. 16 single and 2 double en-suite rooms. Other options such as relocating the service to an alternative site in South Tipperary where Capital developments works will occur are also being considered. There is no capital funding secured to meet this requirement, but a business case to support this capital development will be submitted once plans are finalised.

Proposed Timescale: On-going April 2019

Proposed Timescale: 30/04/2019

Outcome 17: Residents' clothing and personal property and possessions**Theme:**

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

To provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

14. Action Required:

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:

Discussions are on-going with Technical Services in relation to the development of plans for an extension to St. Brigid's Hospital which would comply with HIQA Environmental Standards i.e. 16 single and 2 double en-suite rooms. Other options such as relocating the service to an alternative site in South Tipperary where Capital developments works will occur are also being considered. There is no capital funding secured to meet this requirement, but a business case to support this capital development will be submitted once plans are finalised.

Proposed Timescale: On-going April 2019

Proposed Timescale: 30/04/2019

Outcome 18: Suitable Staffing

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

To ensure that staff have access to appropriate training including training in end of life care.

15. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

Staff members will receive training in end of life care

3 staff members are scheduled to undertake the palliative care module in Waterford University Hospital in October 2017

Proposed Timescale: 31/10/2017